

Pitman Panther Club
Pitman School District
420 Hudson Avenue
Pitman, NJ 08071
(856) 589-2145

2019-2020 School Year Emergency Contact Form

Child's Name: _____ Grade: _____ Teacher: _____ School: _____ Birth Date: _____

Child's Address: _____

Primary Email Address: _____

Sibling (include ages) of Above Named Student:

- 1. _____ 2. _____
- 3. _____ 4. _____

Mother's Name: _____ Father's Name: _____

Mother's Address: _____ Father's Address: _____

Mother's Home Phone: _____ Father's Home Phone: _____

Mother's Cell Phone: _____ Father's Work Phone: _____

Mother's Work Phone: _____ Father's Cell Phone: _____

Mother's Email: _____ Father's Email: _____

Emergency Contact Name (*Not Parent*): _____ Relationship: _____

Emergency Contact Phone: _____ Cell: _____ Work: _____

The following adults are given permission to pick up my child/children from Panther Club Program:

- 1. Name: _____ Address: _____ Phone: _____
- 2. Name: _____ Address: _____ Phone: _____
- 3. Name: _____ Address: _____ Phone: _____

Please List any person(s) NOT permitted to pick-up your child/children:

- 1. Name: _____ Relationship: _____
- 2. Name: _____ Relationship: _____

____ Check here if: **IDO NOT** grant my permission for photographs or videos of my child, or any of his/her work to be submitted to newspapers or TV stations for publication or posted on the Pitman School District website.

MEDICAL INFORMATION

***Any medical conditions must be disclosed at the time of registration. We may not be able to accept your child due to state regulations; only a registered nurse can administer medications. Panther Club does not employ a nurse outside of normal school hours.**

CHECK IF THE STUDENT HAS ANY OF THE FOLLOWING CONDITIONS:

<input type="checkbox"/> Heart Condition: Restrictions	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Seizure Disorder		
<input type="checkbox"/> Asthma: On medication	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Adverse Drug Reaction			<input type="checkbox"/> Severe Allergies (including food or bee stings)		
<input type="checkbox"/> Hearing Problems:	<input type="checkbox"/> Ear tubes	<input type="checkbox"/> aids	<input type="checkbox"/> Braces		
<input type="checkbox"/> ADHD: On Medication	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> Vision problems: Glasses	<input type="checkbox"/> Contacts	<input type="checkbox"/>
<input type="checkbox"/> Other:	_____		<input type="checkbox"/> Fractures	<input type="checkbox"/> year	

Please explain any of the above questions if they are checked:

My child is on the following medication: _____

Recent surgery, illnesses, or injuries and date(s): _____

Family Physician: _____

Family Dentist: _____

Does your child have health insurance? Yes No

If yes, name of insurance company: _____

In case of an **EMERGENCY** and your child has to be taken to the nearest hospital, your preference is: _____
_____. I give my son/daughter permission to receive emergency hospital treatment, if necessary.

I hereby give permission to release information regarding my child's health condition(s) to essential school personnel and those authorized on the emergency card who assume temporary care of my child in order to best meet the medical and health needs of my child in the school setting.

Signature of Parent/Guardian

Date